

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/15/2010
FORM APPROVED
OMB NO. 0938-0391

Poc # acceptable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/07/2010
NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 38585		
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F 000	<p>INITIAL COMMENTS</p> <p>During complaint investigation numbers TN00025518, TN000255192, TN00025744, TN00025582, TN00026449, conducted on August 24, 2010, through October 7, 2010, at Generations of Spencer, no deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.</p> <p>An investigation for complaints TN00026703 and TN00025564 was conducted August 24, 2010, through October 7, 2010. F226 was cited a D Level.</p> <p>An investigation for complaint TN00026809 was conducted October 5 through 7, 2010. The investigation determined the facility failed to prevent an elopement (off the facility property) for one resident (#11). The facility's failure to prevent the elopement placed one resident (#11) in Immediate Jeopardy.</p> <p>The Administrator, Assistant Administrator, and the Director of Nursing were notified of the Immediate Jeopardy and Substandard Quality of Care on October 6, 2010 at 3:30 p.m., in the Administrator's office. A partial extended survey was conducted on October 7, 2010.</p> <p>The Immediate Jeopardy at F 323 cited at a "J" level was effective from September 12, 2010 through October 6, 2010, and was removed on October 6, 2010, based on corrective actions implemented and verified through observations, interviews, policy review, and verification of staff in-service on site by the surveyor on October 7, 2010. Non-compliance continues at a "D" (no harm with potential for more than minimal harm</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] Assistant Administrator 10/28/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 that is not an Immediate Jeopardy) level for monitoring of Quality Assurance corrective actions. The facility is required to submit a plan of correction.	F 000			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation, policy review, review of personnel files and interview, the facility failed to implement the Abuse policy for three (#3, #4, #10) of sixteen residents reviewed. The findings included: Resident #3 was admitted to the facility on March 19, 2010, with diagnoses including Traumatic Brain Injury, Dementia, Aphasia, and Psychosis and expired on May 1, 2010. Medical record review of the Minimum Data Set dated March 31, 2010, revealed the resident had short and long term memory impairment and severely impaired cognitive skills for decision making. Review of the facility investigation dated April 12, 2010, revealed an allegation of verbal abuse towards resident #3 was made on April 10, 2010. Continued review revealed "Nursing Assistant (NA) #1(accused) and Certified Nursing Assistant	F 226	POC #2 The requirement was not met as evidenced by: The facility failed to implement abuse policy for three of six residents reviewed. Staff was in-serviced on 04-12-10 through 04-13-10 by the director of nursing, R.N., on reporting abuse to facility management (see attachment A) An additional in-service review was conducted on 04-23-10 for all staff reporting abuse to facility management. (See attachment B) A new staff orientation protocol was implemented on 10-08-10 to include additional training in reporting abuse to facility management policy for all new hires. (see attachment C) The human resource director, L.P.N. will complete the new orientation training on all new hires effective 10-08-10. Approximately 10% of staff, C.N.A.s and L.P.N.'s were interviewed at random on each shift on 04-12-10 for knowledge of abuse or neglect. Of the staff interviewed, all denied any knowledge of abuse or neglect as evident through a written statement. Social service director continue to next page.....	10/08/10	

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F 226	<p>Continued From page 2</p> <p>#2 came from the dining room with (resident) to put (resident) back in bed, we went in and (the resident) turned around and made a mean face at (Nursing Assistant #1), (Nursing Assistant #1) made a mean face back and call (resident) a *** freak." Continued review revealed the investigation was not initiated until April 11, 2010, when it was reported to the Director of Nursing.</p> <p>Review of the facility abuse policy revealed "...Employees, facility consultants and or attending Physicians must report any suspected abuse or incidents of abuse to the Director of Nursing promptly..."</p> <p>Review of Nursing Assistant #1 personnel file revealed no previous allegations of abuse and NA #1 was suspended April 12, 2010, and did not return to work.</p> <p>Interview with Certified Nursing Assistant #2 on August 25, 2010, at 10:00 a.m., in the Director of Nursing office confirmed on April 10, 2010, witnessed Nursing Assistant #1 "make mean face back and call (resident) a *** freak in a non joking manner", and thought the incident was reported the next day but was unable to recall to whom, and did not report the incident immediately.</p> <p>Telephone Interview with Licensed Practical Nurse #3 (on duty at the time of allegation) on August 25, 2010, at 1:00 p.m., was unable to recall any details of the allegation and unsure if the Director of Nursing was notified at the time of the incident.</p> <p>Interview with the Director of Nursing on August 25, 2010, at 10:30 a.m., in the Director of Nursing</p>	F 226	<p>continue from previous page....</p> <p>in conjunction with case managers interviewed 100% of residents on 04-12-10 and 04-13-10 through personal interviews. The interviews consisted of verbal questions, visual evaluations of changes in mood, eye contact, social interaction and facial expressions. Also further evaluation of physical signs of abuse were performed by the treatment nurse, L.P.N. via skin assessment. The skin assessment will continue to be performed weekly on each resident. Of the 100% of residents interviewed there were no signs of abuse or neglect. Quarterly in-service will be held for all staff in regards to policy and procedure for abuse, neglect, and reporting effective 04-23-10 by social service director. The quality assurance director, L.P.N. will provide oversight and monitor for compliance of the abuse policy through 20% of residents and 10% of staff interviews monthly for three months, following each new hire within the first thirty days and semi-annually thereafter, effective 10-08-10. The quality assurance director, L.P.N. will report all findings to the quality assurance committee as needed. Social service director in conjunction with case managers will meet with each resident twice monthly to evaluate for changes in mood, continue to next page.....</p>	10/08/10	

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F 226	<p>Continued From page 3</p> <p>office, confirmed the allegation of verbal abuse was witnessed on April 10, 2010, and was not reported to Administration until April 12, 2010, and the abuse policy was not implemented timely. Continued interview revealed NA #1 was suspended April 12, 2010, and did not return to work.</p> <p>Resident #4 was admitted to the facility on January 29, 2010, with diagnoses including Schizoaffective Disorder, Psychosis, Diabetes and Hepatitis C.</p> <p>Medical record review of the Minimum Data Set dated February 11, 2010, revealed the resident had long and short term memory impairment and moderately impaired cognitive skills for decision making.</p> <p>Medical record review of the facility investigation dated April 11, 2010, revealed Certified Nursing Assistant #6 reported an allegation of verbal abuse towards resident #4. Continued review revealed "Nursing Assistant #1 (accused) and Certified Nursing Assistant #6 was changing (resident) and (resident) stated would rather...back to bed...(Nursing Assistant #1) said to (resident) 'what the...your not going back to bed...told (resident) if (resident) went back to bed (Nursing Assistant #1) wasn't getting (resident) back up when (resident) wanted up..."</p> <p>Telephone Interview with Licensed Practical Nurse #3 (on duty at the time of allegation) on August 25, 2010, at 1:00 p.m., was unable to recall any details of the allegation.</p> <p>Telephone interview with Certified Nursing</p>	F 226	<p>continue from previous page.....</p> <p>eye contact, social interactions and facial expressions, reporting any changes to the resident's charge nurse, L.P.N. The facility process/ chain of command for reporting and time frames to report an allegation of abuse, neglect or misappropriation of funds is staff, facility consultants and attending physicians must report any suspected abuse or incidents of abuse to the director of nursing, R.N. promptly. In the absence of the director of nursing, R.N. such reports are to be made to the nurse supervisor, L.P.N. on duty. The administrator and director of nursing, R.N. must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the administrator and director of nursing, R.N. must be called at home or be paged and informed of such incidents. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the appropriate agencies and persons. Abuse must be reported immediately and a completed copy of the "resident abuse report form" and written statements from witnesses, if any, must be provided to the administrator within 72 hours of</p> <p>continue to next page.....</p>	10/08/10	

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F 226	<p>Continued From page 4</p> <p>Assistant #6 on September 16, 2010, at 4:35 p.m., confirmed on April 11, 2010, Certified Nursing Assistant #6 witnessed Nursing Assistant #1 tell the resident "what the ...your not going back to bed ...told (resident) if (resident) went back to bed (Nursing Assistant #1) wasn't getting (resident) back up when (resident) wanted up..." Further interview confirmed Certified Nursing Assistant #6 was unsure to whom or when the incident was reported.</p> <p>Interview with the Director of Nursing on August 25, 2010 at 10:30 a.m., in the Director of Nursing office, confirmed the allegation of verbal abuse was witnessed on April 11, 2010, and was not reported to the Director of Nursing until April 12, 2010, and the abuse policy was not implemented timely. Further interview confirmed Nursing Assistant #1 was suspended on April 12, 2010 and did not return to work.</p> <p>Resident #10 was admitted to the facility on December 11, 2007 with diagnoses including Dementia, Mental Retardation, and Diabetes.</p> <p>Medical record review of the Minimum Data Set dated March 3, 2010, revealed the resident had long and short term memory impairment and moderately impaired cognitive skills for decision making.</p> <p>Medical record review of the facility investigation completed on August 30, 2010, for an incident dated April 10, 2010, revealed Certified Nursing Assistant #2 reported an allegation of verbal abuse and inappropriate touching of resident #10 on April 12, 2010, according to Certified Nursing</p>	F 226	<p>continue from previous page.....</p> <p>the occurrence of such incident. An immediate investigation will be completed and a copy of the findings of such investigation will be provided to the administrator within three working days of the occurrence of such incident. There are IDT meetings daily, Monday through Friday to review incident reports and place interventions as needed. The direct care staff, C.N.A., L.P.N., R.N. will complete interventions placed by the IDT and evaluate daily for effectiveness of interventions and verbally report findings to the director of nursing, R.N. The director of nursing, R.N. will evaluate the effectiveness of interventions put in place for each resident and review findings during the daily IDT meeting. The director of nursing, R.N. will also present information to the quality assurance committee, monthly. The quality assurance director, L.P.N. will trend information on staff awareness and any new complaints monthly.</p>	10/08/10	

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F 226	Continued From page 5 Assistant #2. Continued review revealed "We (accused and Certified Nursing Assistant #2) went to (resident's) room to put (resident) to bed and (Nursing Assistant #1) poked (resident's) belly and (resident) poked (Nursing Assistant #1) chest and (Nursing Assistant #1) said stop in a playful manner then poked (resident) again and (resident) poked (Nursing Assistant #1) back. Then (Nursing Assistant #1) took (resident's) handkerchief and waved it in front of (resident's) face and told (resident) to say tell me how bad you want to go to bed, (and) resident said bad ...resident's hand went up Nursing Assistant #1 shirt. Review of the facility abuse policy revealed "...Employees, facility consultants and or attending Physicians must report any suspected abuse or incidents of abuse to the Director of Nursing promptly..." Interview with Certified Nursing Assistant #2 on August 25, 2010, at 10:00 a.m., in the Director of Nursing office confirmed the events of the above incident. Continued interview confirmed this was reported to Administration on April 12, 2010. Interview with the Administrator, Assistant Administrator and the Director of Nursing on August 25, 2010, at 11:00 a.m., in the office revealed no knowledge of the above incident, and no investigation was initiated prior to August 25, 2010. C/O TN000026703 and TN00025564	F 226		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	POC #2 The requirement is not met as evidenced by the facility failed to prevent the elopement of resident #11, one of sixteen residents reviewed. continue to next page	10/25/10

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F 323	<p>Continued From page 6</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, review of Environmental Check sheets, review of Safety Committee minutes, observation and interview, the facility failed to prevent the elopement off the facility's property for one resident (#11) of sixteen residents reviewed. The facility's failure to prevent the elopement (off the facility property) placed resident #11 at risk for harm and in Immediate Jeopardy.</p> <p>The Administrator, Assistant Administrator, and the Director of Nursing were notified of the Immediate Jeopardy and Substandard Quality of care on October 6, 2010 at 3:30 p.m., in the Administrator's office.</p> <p>The Immediate Jeopardy was effective from September 12, 2010, through October 6, 2010, and was removed on October 6, 2010, based corrective actions implemented and verified through observations, interviews, policy review, and verification of staff in-service on site by the surveyor on October 7, 2010. Non-compliance continues at a "D" (no harm with potential for more than minimal harm that is not an Immediate Jeopardy) level for monitoring of corrective actions.</p> <p>The findings included:</p>	F 323	<p>continue from previous page...</p> <p>Upon return to the facility the resident was immediately placed on one-on-one supervision on 09-12-10. The medical director, mental health nurse practitioner, and mobile crisis were each notified for an assessment. All door alarms were checked by the maintenance worker on 09-12-10, following the elopement to ensure the equipment was functioning properly. All residents were re-evaluated for elopement potential by assistant director of nursing, L.P.N., and assisting L.P.N. on 10-08-10. There were seven residents on the elopement risk assessment program on 10-08-10, upon re-evaluation of all residents for elopement risk, four residents remained on the program. Also upon re-evaluation for elopement potential, additional individualized interventions were placed for those residents at high risk. Example: resident #583 received yellow shoe laces and yellow designed tape on head of bed and on wheelchair to alert staff of elopement potential. The elopement monitoring forms were revised on 10-08-10 to reflect every one hour visual checks to be completed by C.N.A. (see attachment D) All staff were in-serviced on elopement policy and procedures on 09-23-10 by</p> <p>continue to next page.....</p>	10/25/10	

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F 323	<p>Continued From page 7</p> <p>Resident #11 was admitted to the facility on September 2, 2010 with diagnoses including Dementia, Schizophrenia, Chronic Obstructive Pulmonary Disease and Manic Depressive Psychosis.</p> <p>Medical record review of the Minimum Data Set dated September 15, 2010, revealed the resident had long and short term memory impairment, had modified independence with daily decision making skills; was independent with ambulation in the room and required supervision with ambulation in the hallway. Continued review revealed the resident exhibited wandering behavior 4-6 times but not daily in the last seven days and the behavior was not easily altered.</p> <p>Medical record review of the Elopement Risk Assessments dated September 2, September 10, and September 27, 2010, revealed the resident was at high risk for elopement.</p> <p>Medical record review of the interim care plan revealed the resident was at risk for elopement and the facility had care planned to provide for safe wandering, involve in activities, redirect resident and evaluate exit seeking behavior to determine cause/pattern.</p> <p>Medical record review of the Nurse's note dated September 3, 2010, at 1315 (1:15 p.m.) revealed "resident agitated trying to exit building out all of exits. Nurse Practitioner notified...has been redirected (with) some success..."</p> <p>Medical record review of the documentation of every 15 minutes checks dated September 3,</p>	F 323	<p>continue from previous page ...</p> <p>assistant administrator. (see attachment E). An elopement drill was performed on 10-08-10 by the safety officer, C.N.A. All staff participating completed the drill successfully. (see attachment F) The frequency of elopement drills was increased to monthly alternating shifts (see attachment G) Security Equipment completed an on-site assessment on 09-13-10 changing all codes to access doors. (see attachment H) Security Equipment completed an on-site assessment on 10-08-10 for potential placement of an roaming alert system. (see attachment I). Security Equipment, during the on-site visit conducted on 10-08-10 altered the exterior door code system to continuously sound alarms until codes are manually re-entered. Elopement policy was updated on 10-11-10 to reflect the changes in the elopement procedures. The elopement policy and procedure was approved by the board of directors on 10-11-10 and reviewed by the medical director on 10-22-10. (See attachment J)</p> <p>Visual checks will be completed by a designated C.N.A. to include the exact location and activity of the resident at the time of the check. The nurse, L.P.N. will visualize</p> <p>continue to next page</p>	10/25/10	

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F 323	<p>Continued From page 8</p> <p>2010, revealed the resident was placed on every fifteen minute checks and the checks have continue through October 7, 2010.</p> <p>Medical record review of the Nurse's note dated September 4, 2010, at 0900 (9:00 a.m.) revealed "...res (resident) appears very anxious. Standing (with) both arms crossed speech clear. Refused to allow this Nurse to touch and assess (resident) at this time. Res attempted to go out 100 hall door x (times) 2 and lobby door x1 this a.m. Redirected (with) success (after) several attempts..."</p> <p>Medical record review of the Nurse's note dated September 4, 2010, revealed "...at beginning of shift was going to doors and sounding alarm. Resident out 300 hall (at) one point sitting on bench. Nurse had to encourage res to come back in building. Rsd (resident) came back in and then to dining room...rsd did not exhibit any (increase) agitation..."</p> <p>Medical record review of the Nurse's note dated September 6, 2010, 1600 (4:00 p.m.) revealed "Rsd went out 100 hall door and followed by CNA (Certified Nursing Assistant) rsd went around to front of building and sat on picnic table. CNA's and Nurses out to assist (with) getting rsd back in building. After sitting at table for 10 minutes rsd returned to inside of building...Upon returning inside of building rsd (resident) cont (continued) to go from door to door pushing on doors. Explained to rsd that (resident) could not be outside alone..."</p> <p>Medical record review of the Nurse's note dated September 8, 2010, at 0800 (8:00 a.m.) revealed "medicated with PRN (as needed) Alivan</p>	F 323	<p>continue from previous page...</p> <p>the location of the resident and verify the documentation hourly by initially the Q15 minute check form (see attachment A-1) effective 10-25-10. If the designated C.N.A. is unavailable to complete the Q15 minute visual check and documentation he or she must report to the nurse, L.P.N. for designation of coverage. The quality assurance director, L.P.N. will complete random visual checks of each resident and documentation for the next thirty days then monthly for three months and quarterly thereafter to ensure compliance with the Q15 minute visual checks and report findings to the quality assurance committee. The quality assurance director, L.P.N. will evaluate 100% of residents monthly, considered high risk for elopement. Any concerns related to the findings will be reported immediately to the director of nursing, R.N. by the quality assurance director, L.P.N. The safety officer, C.N.A. will complete weekly visual inspections of 100% of residents identified at high risk of elopement. The safety officer, C.N.A. will report any needed changes to the current elopement identification system to the director of nursing, R.N. and quality assurance director, L.P.N. immediately.</p>	10/25/10	

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F 323	<p>Continued From page 9</p> <p>(medication used for anxiety) d/t (due to) (increased) agitation pacing, going to exit doors and difficult to redirect..."</p> <p>Medical record review of the Nurse's note dated September 9, 2010, at 0700 (7:00 a.m.) revealed "...attempting to go out 300 hall door sounding alarm. When this Nurse attempted to redirect back to room rsd became agitated. Yelling out and cursing. Assisted rsd into DR (dining room) for breakfast. Gave po (by mouth) prn Ativan..."</p> <p>Medical record review of the Nurse's note dated September 11, 2010, revealed "...Resident ambulating up and down halls quite frequently this shift. Attempting to open front door 200 hall door and 400 hall door. Staff was able to redirect resident successfully. Resident displayed (no) signs of increased agitation (with) staff this shift."</p> <p>Medical record review of the Nurse's note dated September 12, 2010, at 1805 (6:05 p.m.) revealed "A resident (good samaritan) of Van Buren County (witness #1) notified staff member of a strange...man whom...believed to be a resident of this facility walking along side the court house. Code Forrest (code to alert staff to potential elopement) initiated immediately. Resident (#11) not to be found in the facility. Law enforcement and rescue squad notified. Licensed Practical Nurse #1, Environmental Services employee #1, and Certified Nursing Assisted #1 left facility via personal vehicle to search for resident. The remaining staff searched grounds. (witness #1) returned resident to facility per personal vehicle. Head to toe assessment complete. Resident's status unaltered d/t (due to) elopement...Resident stated 'I was going home to my mother'. Resident placed on (one on one)</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>care per staff." Continued review revealed the Assistant Administrator, Director of Nursing, Social Services, Physician and responsible party were notified.</p> <p>Review of the Elopement Policy revealed "...Code Forrest will be the code to alert staff of potential elopement..."</p> <p>Medical record review of the documentation of every fifteen minute checks dated September 12, 2010, revealed the resident was documented as "walking" (within facility) at 6:00 p.m. and 6:15 p.m., at 6:30 p.m., "left the building". Continued review revealed at 6:45 p.m. "found and back in building..."</p> <p>Review of the facility investigation dated September 12, 2010, revealed "...no injuries noted. Alarms checked and verified ensure working. Resident on elopement program. NP (Nurse Practitioner) seen on Monday for eval (evaluation) and med (medication) review..."</p> <p>Review of the environmental checks documentation to include door alarm checks dated September 12, 2010, through September 18, 2010, revealed on September 12, 2010, the door alarms were checked every two hours and documented as functioning.</p> <p>Medical record review of the documentation of one on one observation revealed the resident was placed on one on one observation on September 12, 2010, (after elopement) at 10:00 p.m. through September 15, 2010.</p> <p>Medical record review of the Social Services notes dated September 13, 2010 through October</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>1, 2010, revealed multiple attempts were made to find alternate placement for the resident.</p> <p>Medical record review of the Nurse's note dated September 13, 2010, at 1800 (6:00 p.m.) revealed "...attempting to exit facility through doors x 3. Resid (resident) redirected x2 staff effective (at) this time..."</p> <p>Medical record review of the Mental Health Nurse Practitioner note dated September 13, 2010, revealed "...Will add Haldol (antipsychotic medication) IM (intramuscular) every two weeks, increase Neurontin to 600 mg (milligrams) bid (twice a day) for mood, and Klonopin 1 mg at 8am and 4pm..."</p> <p>Medical record review of the Physician's order dated September 13, 2010, revealed "D/C (discontinue) Ativan (at) 8am (and) 1pm. Klonopin 1mg (at) 8am (and) 1pm."</p> <p>Medical record review of the care plan dated September 15, 2010, revealed the resident was at risk for elopement and the facility had implemented "...Assist in orientation to facility and room with verbal cues. Encourage group activities and attempt to keep occupied. Monitor resident's location with frequent visual checks. Put familiar items in resident's room to assist (resident) in identifying (resident's) room..."</p> <p>Review of the facility safety committee meeting minutes dated September 16, 2010, revealed "...addition of tint to windows on the doors to draw less attraction to exit doors..."</p> <p>Medical record review of the Nurse's note dated September 18, 2010, revealed "...rsd (resident)</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>was at exit doors pushing on them. Did go out door x1. Rsd passed in hallway several times and required redirecting to room..."</p> <p>Observation on October 5, 2010, at 11:00 a.m., revealed the resident asleep in bed with a yellow bracelet on the wrist and a balloon attached to the resident's door.</p> <p>Interview with the Director of Nursing and the Assistant Administrator on October 5, 2010, at 11:00 a.m., in the Director of Nursing office, confirmed on September 12, 2010, a little after 6:00 p.m., received a call from staff that the resident had eloped. Continue interview confirmed Code Forrest was initiated by staff after witness #1 reported to the staff a resident was seen off the property. Further interview confirmed the staff on duty were interviewed and denied hearing a door alarm, and confirmed no written staff statements were obtained prior to October 5, 2010. Continued interview confirmed the resident was returned to the facility by witness #1 and was found without injuries.</p> <p>Interview with Social Services on October 5, 2010, at 12:30 p.m., in the Director of Nursing Office confirmed multiple attempts have been made for alternate placement but have been unsuccessful.</p> <p>Interview with LPN (Licensed Practical Nurse) #1 (on duty at the time of the incident on September 12, 2010) on October 5, at 2:00 p.m., in the Director of Nursing office, confirmed on September 12, 2010, Environmental Services employee #1 reported the resident got out of the building. Continued interview confirmed Code Forrest was initiated, the Director of Nursing and</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>police were notified, and denied hearing any door alarm sound.</p> <p>Interview with Environmental Services employee #1 on October 5, 2010, at 2:15, p.m., in the Director of Nursing office confirmed on September 12, 2010, Environmental Services employee #1 heard witness #1 report resident maybe off the property. Continued interview confirmed all door alarms were checked at 6:00 p.m., as documented on the environmental checks documentation, and upon notification of the elopement Environmental Services employee notified CNA #2, and all door alarms were checked again and a gate on the grounds outside of the 300 hall was unlatched.</p> <p>Interview with Certified Nursing Assistant #1 (assigned to the resident at the time of the incident on September 12, 2010) on October 5, 2010, at 2:25 p.m., with the Director of Nursing present, in the Director of Nursing's office confirmed, CNA #1 was assigned to the resident, and was aware the resident required every fifteen minute checks due to exit seeking behavior. Continued interview confirmed CNA #1 made a visual check documented at 6:00 p.m; however, CNA #1 was assigned to the dining room and the and did not make a visual check as documented at 6:15 p.m. Further interview confirmed a Code Forrest was initiated and CNA #1 assisted in the search for the resident.</p> <p>Telephone interview with LPN #2 (on duty at the time of the incident on September 12, 2010) October 5, 2010, at 7:15 p.m., confirmed September 12, 2010, the resident did elope from the facility property. Continued interview</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>confirmed a Code Forrest was initiated and LPN #2 and two other employees got in private vehicle to search for the resident. Further interview confirmed no door alarm was heard.</p> <p>Telephone interview with witness #1 on October 6, 2010 at 8:20 a.m. confirmed on September 12, 2010, while driving witness #1 noticed a male walking down the sidewalk. Continued interview revealed witness #1 thought it might be a resident from the facility and witness #1 went to the facility and notified staff (unsure name of staff). Continued interview confirmed witness #1 returned to their private vehicle and drove down the road and found the resident walking on the side of the road, (about 1/2 mile from the facility) called the resident by name, and the resident got into the vehicle and was returned to the facility. Further interview confirmed from that approximately 15 to 20 minutes had elapsed from the time witness #1 saw the resident walking until the resident was returned to the facility.</p> <p>Interview with the Safety Officer on October 6, 2010, at 9:25 a.m. in the office, revealed the Interdisciplinary Safety Committee met on September 18, 2010, the elopement was discussed and the committee recommended tinting of the windows on the doors.</p> <p>Telephone interview with CNA #3 (on duty September 12, 2010) on October 6, 2010, at 10:00 a.m., confirmed on September 12, 2010, a Code Forrest was initiated after witness #1 notified the facility of the elopement, and Certified Nursing Assistant #3 got in vehicle to assist in searching for the resident. Continued interview confirmed Certified Nursing Assistant #3 did not</p>	F 323			

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F 323	<p>Continued From page 15 hear a door alarm.</p> <p>Telephone interview on October 6, 2010, at 10:15 a.m. with CNA #4 (on duty at the time of the incident on September 12, 2010) confirmed Environmental Services employee #1 came to the dining room and reported to Certified Nursing Assistant #4 that a resident had been seen up at the court house. Continued interview confirmed the elopement was reported to LPN #2. Further interview confirmed CNA #4 did not recall hearing a door alarm sound.</p> <p>Observation of the elopement site and interview on October 6, 2010, at 11:00 a.m., with the Director of Nursing and the Assistant Administrator confirmed the resident went approximately 1/2 to 3/4 of a mile from the facility property. Further observation revealed two intersections between the facility and the location the resident was located. Continued observation revealed 5 cars passed through the intersection in a 7 minute period.</p> <p>Interview with the Administrator, Assistant Administrator and the Director of Nursing on October 6, 2010, at 1:00 p.m., in the Administrator's office, confirmed the resident was placed on every fifteen minute checks beginning September 3, 2010, related to exit seeking behaviors. Continued interview confirmed on September 12, 2010, the resident eloped off the facility property without staff knowledge and staff were made aware of the elopement by witness #1; the resident was gone approximately 20 minutes before being returned to the facility by witness #1, and upon return resident #11 was placed on one on one supervision for 48 hours. Further interview confirmed the facility had</p>			F 323			

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F 323	<p>Continued From page 16</p> <p>implemented the following interventions after resident #11 eloped: the alarm company changed the key pad codes for all exit doors on September 13, 2010; Mental Health Nurse Practitioner evaluated the resident on September 13, 2010, and ordered medication changes; Social Services began looking for alternate placement on September 13, 2010; all staff in-service on elopement was conducted on September 23, 2010; the facility began tinting of the exit door windows on the week of September 24, 2010, and completed the tinting on October 5, 2010; the residents identified at risk for elopement were reassessed by October 6, 2010; beginning October 5, 2010, all nursing staff were in-serviced on documentation and every fifteen minute checks until 100% all nursing staff have been in-serviced prior to returning to work the next scheduled shift.</p> <p>The facility's corrective actions were confirmed through observation, documentation review, and interview of multiple staff to remove the Immediate Jeopardy.</p> <p>Observation on October 6, 2010, with the Director of Nursing at 11:15 a.m., revealed all residents identified at risk for elopement had a yellow bracelet on the wrist and a balloon on the residents' room doors as per the facility elopement policy; exit doors were tinted and alarms were functioning.</p> <p>Review of the Elopement Risk Assessments for the residents identified at risk for elopement were updated by October 6, 2010.</p> <p>Review of in-service records revealed all staff were in-serviced on elopement on September 23,</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>2010, and in-service for all nursing staff on documentation and every fifteen minute checks began on October 5, 2010.</p> <p>Multiple staff including environmental services and Nursing staff including LPN's, RN's (Registered Nurses), CNA's on multiple shifts were interviewed from October 5, 2010, through October 7, 2010, and confirmed they have been in-serviced on interventions and monitoring to prevent elopement, accurate documentation and visual observation for monitoring wandering residents when completing every 15 minute checks.</p> <p>Verification of the facility's interventions was completed by record review, observation and interview October 5, 2010, through October 7, 2010, to confirm the facility had removed the Immediate Jeopardy (A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) from a "J" level to "D" level (no actual harm with potential for more than minimal harm that is not an Immediate Jeopardy) effective October 6, 2010, and noncompliance continues at a "D" level.</p>			F 323			
F 514 SS=D	<p>C/OTN00026809</p> <p>483.75(l)(1) RES</p> <p>RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p>			F 514	<p>POC #2</p> <p>The requirement is not met as evidenced by: the facility failed to maintain an accurate medical record for one resident, #11, of sixteen resident's reviewed. On 10-08-10 C.N.A. #1 was placed on unpaid leave pending investigation by the director of nursing, R.N. continue to next page.....</p>		10/22/10

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F 514	<p>Continued From page 18</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain an accurate medical record for one resident (#11) of sixteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #11 was admitted to the facility on September 2, 2010, with diagnoses including Dementia, Schizophrenia, Chronic Obstructive Pulmonary Disease and Manic Depressive Psychosis.</p> <p>Medical record review of the Nurse's note dated September 12, 2010, at 1805 (6:05 p.m.) revealed "A resident of Van Buren County (witness #1) notified staff member of a strange...man whom (resident of Van Buren County) believed to be a resident of this facility walking along side the court house. Code Forrest (missing resident procedure) initiated immediately. Resident (#11) not to be found in the facility. Law enforcement and rescue squad notified. Licensed Practical Nurse #1, Environmental Services employee #1, and Certified Nursing Assisted (CNA) #1 left facility via personal vehicle to search for resident. The remaining staff searched grounds. Resident of</p>	F 514	<p>continue from previous page.....</p> <p>Upon completion of the investigation into her documentation, 10-13-10, C.N.A. #1 was re-educated on documentation standards, elopement procedures, falsification of documentation and potential legal implications. An in-service on documentation standards was completed on 10-05-10 and 10-06-10 by the assistant director of nursing, L.P.N. (see attachment K) The titles of the employees inserviced on documentation standards are C.N.A.'s, L.P.N.'s and R.N.'s A secondary in-service was completed on 10-22-10 to include all staff on documentation standards. The quality assurance director, L.P.N. will interview 10% of staff monthly to ensure the maintenance of a working knowledge of documentation standards for no less than six months and present findings to the quality assurance committee. All new hires will be orientated on documentation standards and legal implications of falsification of documentation by the human resource director, L.P.N. (see attachment C) An in-service will be completed quarterly on maintenance of accurate medical records and documentation by the director of nursing.</p>	10/22/10	

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F 514	<p>Continued From page 19</p> <p>Van Buren County returned resident (#11) to facility per personal vehicle. Head to toe assessment complete. Resident's status unaltered d/t (due to) elopement...Resident stated 'I was going home to my mother.' Resident placed on (one on one) care per staff." Continued review revealed the Assistant Administrator, Director of Nursing, Social Services, Physician and responsible party were notified.</p> <p>Medical record review of the documentation of every fifteen minute checks dated September 12, 2010, revealed the resident was documented as "walking" (within the facility) at 6:00 p.m. and 6:15 p.m. Continued review revealed at 6:45 p.m. "found and back in building..."</p> <p>Interview with CNA #1 (assigned to the resident at the time of the incident on September 12, 2010) on October 5, 2010 at 2:25 p.m., with the Director of Nursing present, in the Director of Nursing's office confirmed, CNA #1 was assigned to the resident and was aware the resident required every fifteen minute checks due to exit seeking behavior. Continued interview confirmed CNA #1 made a visual check documented at 6:00 p.m.; however, CNA #1 was assigned to the dining room and did not make a visual check as documented at 6:15 p.m.</p> <p>Interview with the Director of Nursing in the Director of Nursing's office, on October 5, 2010, at 2:40 p.m. confirmed the medical record was not accurate.</p> <p>C/OTN00026809</p>	F 514			